CaliforniaKids Enrollment Form

Please print or type ALL information.
THIS IS NOT A TEMPORARY IDENTIFICATION CARD.

Section 1 LIST ALL CHILDREN IN THE FAMILY If selected in the CaliforniaKids Program, each person listed below must receive all medical care through the Medical Group or Independent Practice Association (IPA) selected, must be between the ages of 2 through 18, and must live within 30 miles of the group selected. Please see your CaliforniaKids Directory when selecting a Medical Group or IPA. IF YOU SELECT AN IPA, YOU MUST SELECT A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA and indicate the physician code below. If you need assistance, contact 1 (800) 374-4KID.

Children	Last Name	First Name	M.I.	Age	Date of Birth MO DAY YR	Name of school enrolled in:	Social Security No.	Medical Group IPA Office	IPA Primary Care Physician Code
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0
☐ MALE ☐ FEMALE									0

Section 2 **ARE ANY OF THE ABOVE CHILDREN ELIGIBLE FOR ANY STATE OR FEDERAL HEALTH CARE BENEFIT PROGRAMS? IF YES, PLEASE LIST ELIGIBLE CHILD(REN) AND PROGRAM(S):**

Name: _____ Program: ☐ Medi-Cal ☐ CHDP ☐ CCS ☐ Explain _____

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Name: _____ Program: ☐ Medi-Cal ☐ CHDP ☐ CCS ☐ Explain _____

Section 3 **Have any of the above children been enrolled in the Access for Infants and Mothers program (AIM)** ☐ YES ☐ NO

Section 4 **DO THE CHILDREN IN SECTION 1 RESIDE WITH YOU FULL TIME?** ☐ YES ☐ NO

Section 5 **ARE ANY OF THE ABOVE CHILDREN COVERED BY ANY HEALTH INSURANCE COMPANY?** ☐ YES ☐ NO **IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION.**

FIRST NAME	INSURANCE NAME/ID #	PHONE NUMBER
FIRST NAME	INSURANCE NAME/ID #	PHONE NUMBER

Section 6 **PARENT / GUARDIAN / STEPPARENT / OR OTHER / LIVING WITH CHILD(REN) INFORMATION**

MOTHER LAST NAME	FIRST NAME	EMPLOYER NAME	FATHER LAST NAME	FIRST NAME	EMPLOYER NAME
SOCIAL SECURITY NO.	HOME TELEPHONE NO. ( )	WORK TELEPHONE NO. ( )	SOCIAL SECURITY NO.	HOME TELEPHONE NO. ( )	WORK TELEPHONE NO. ( )
CHILD(REN) HOME ADDRESS	CITY	STATE / ZIP	CHECK ONE: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED		

Section 7 **Total yearly income of household before taxes**

Total yearly income $ _____ **+ $** _____

+ other income $ _____ **= $** _____ **total yearly income.**

Section 8 **Total # of people living in household as of this date:** _____

Section 9

III. AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION EXPLANATION

Blue Cross is authorized to obtain and release medical information in compliance with the Insurance and Privacy Protection Act, Section 791 et. seq. of the California Insurance Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Blue Cross of California any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.

I also authorize Blue Cross of California, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Master Agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

The effective date of coverage is subject to Blue Cross of California approval.

This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Blue Cross of California to process claims. A photocopy of this authorization shall be as valid as the original.

IV. ARBITRATION AGREEMENT I understand that any dispute or controversy which may arise under the agreement between myself (and or any enrolled family member) and Blue Cross of California, or any participating medical office must be submitted to binding arbitration in lieu of a jury or court trial if the amount in dispute exceeds the jurisdictional limits of small claims court. If any such dispute is within the jurisdictional limits of small claims court, the matter will be resolved in small claims court.

V. I (we) certify that all information listed above on this application form is truthful, complete and accurate. I (we) understand that any false statements or any misrepresentation of facts is grounds for termination from this Program.

YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION FOR YOUR FILES IF REQUESTED

GROUP NO. CALIFORNIACARE	EFFECTIVE DATE MO DAY YR	SIGNATURE OF PARENT/LEGAL GUARDIAN	DATE SIGNED

CC 40 27 9/96

detach here